Reset Form

Tennessee Consolidated Retirement System
502 Deaderick Street
Nashville, TN 37243-0201

OFFICE USE ONLY

☐ RET ☐ INS

SERVICE CREDIT: _____

EFFECTIVE DATE: _____

NEW PARTICIPANT: YES NO

☐ ST ☐ LE ☐ LE-SS ☐ LG

APPROVED BY: _____

Application for the Tennessee Plan Medicare Supplement Program

Tennessee Government Retirees

PLEASE PRINT

To apply for coverage, this form must be returned to TCRS within 60 days of the date of your initial eligibility. If you are enrolled in TennCare, you do not need Medicare Supplement Coverage. **A copy of your Medicare card must be enclosed with this application**.

Retiree Information

Social Security Number	Date of Birth: Month Day Year	Employee ID #:	Male ☐ Female ☐

Name: Last First Middle	Phone Number:

Address: Street (rural route) City State Zip Code

Medicare # _____ Medicare Effective Date: Part A (Month/Day/Year) _____ Part B (Month/Day/Year) _____

I am applying for coverage for the following Medicare eligible individuals:

☐ Myself Only ☐ Myself and My Spouse and/or Dependents ☐ My Spouse and Dependent(s) Only

Spouse's Information *(If applying)*

Spouse's Name: Last First Middle	Sex	Medicare Effective Date
Social Security Number / Date of Birth Month Day Year	Male ☐ Female ☐	Part A (Month/Day/Year) _____ Part B (Month/Day/Year) _____

Dependent's Information *(If applying)*

Dependent's Name: Last First Middle	Sex	Medicare Effective Date
Social Security Number / Date of Birth Month Day Year	Male ☐ Female ☐	Part A (Month/Day/Year) _____ Part B (Month/Day/Year) _____

Other Insurance Information

Are you or any member of your family covered by a group health insurance company or the holder of another health care coverage? ☐ Yes ☐ No If you checked "Yes," please furnish the following:

First Name of Insured:	Place of Employment:
Relationship to Insured: ☐ Myself ☐ Spouse ☐ Dependent	Insurance Company:
ID or Policy Number (if known):	Insurance Company's Address (if known):

(Signature required on back of form.)

The following information must be supplied if you are applying sixty (60) days or more past your first Medicare eligibility date.

Retiree Information

Do you now have or have you had in the last five years any of the following:

Yes	No		If yes, when:
☐	☐	Heart Attack	_____
☐	☐	Cancer (not skin cancer)	_____
☐	☐	Stroke	_____
☐	☐	Kidney Failure	_____

Spouse Information

Do you now have or have you had in the last five years any of the following:

Yes	No		If yes, when:
☐	☐	Heart Attack	_____
☐	☐	Cancer (not skin cancer)	_____
☐	☐	Stroke	_____
☐	☐	Kidney Failure	_____

Dependent Information

Do you now have or have you had in the last five years any of the following:

Yes	No		If yes, when:
☐	☐	Heart Attack	_____
☐	☐	Cancer (not skin cancer)	_____
☐	☐	Stroke	_____
☐	☐	Kidney Failure	_____

I am applying for the Tennessee Plan coverage.

I understand that my Tennessee Plan coverage will be effective on the date shown in the material to be received from the insurance provider. I understand that I will have the right to review the benefits booklet. I understand that if I am not enrolled in Medicare, the Tennessee Plan will not provide benefits. I also understand that if I am enrolled in TennCare, I do not need a supplement plan. I further understand that if I am enrolled in a Medicare HMO, I do not need this supplement plan.

The information provided on this form is accurate and truthful to the best of my knowledge and belief for the purpose of determining my insurance eligibility. I understand that knowingly providing false and/or misleading information may subject me to legal action and may result in loss of insurance coverage and recovery of any claims paid under this contract. I further understand that proof of this information may be requested at any time. I agree to retain Medicare Parts A and B for myself or dependents that are applying. Also, I am aware that the State of Tennessee's supplement does not offer any pharmacy benefits; therefore, I must enroll in Medicare Part D or subscribe to another supplemental for pharmacy needs.

Date _____ Signature of TCRS Retired Member _____

Date _____ Spouse's Signature (if applying) _____

Date _____ Dependent's Signature (if applying) _____

Employer Certification (Must be completed by employer unless you have been retired for more than 60 days.)

Give month, day and year in which coverage will be terminated through employer: _____, 20 _____

Department or Institution _____ Phone Number _____

Signature of Certifying Officer _____